

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048227

DEPARTMENT OF PUBLIC HEALTH

FILED JAN 10 1963

318

1003

12671

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

ST-4531 XC\*1 721 370

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b <b>266 DAYS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>COCHRAN VET. ADM. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3252 SO. GRAND AVE. (APT</b>	
3. NAME OF DECEASED (Type or print) <b>SYLVESTER T. CALLAHAN</b>		4. DATE OF DEATH Month <b>12</b> Day <b>31</b> Year <b>62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN-MCQUAY NORRIS COMPANY</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI, U.S.A.</b>	
13a. FATHER'S NAME <b>CORNELIUS CALLAHAN</b>		13b. MOTHER'S MAIDEN NAME <b>KATE CARMODY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-I</b>		17. INFORMANT Address <b>CAMILLE CALLAHAN (WIDOW) SEE #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ABDOMINAL AORTIC ANEURYSM</b> DUE TO (b) <b>AORTIC ARTERIOSCLEROSIS</b> DUE TO (c) <b>451X A</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PULMONARY TUBERCULOSIS EAR ADVANCED, ACTIVE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20c. TIME OF INJURY Hour <b>VA</b> a.m. Month, Day, Year <b>1/9/62</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>ST. LOUIS, MO.</b>	
21. Attended the deceased from <b>1/9/62</b> to <b>12/31/62</b> and last saw him alive on <b>12/31/62</b> Death occurred at <b>12:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>Robert M. Donati</b> (Degree or title) <b>ROBERT M. DONATI</b> M.D.	
22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>12/31/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 3, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	
24. FUNERAL DIRECTOR <b>KRIEGSHAUSER 4228 S. KINGSHIGHWAY BLVD.</b>		25. DATE FILED BY REG. <b>JAN 2 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James R. Sumner*

Licensed Embalmer No. 4527

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.